

Kansas SHICK Client Counseling Contact Form

ALL AREAS IN RED ARE REQUIRED FIELDS; PLEASE COMPLETE ONE FORM PER CLIENT.

SHICK Counselor Name: _____		SHICK Counselor County: _____		SHICK Coordinating Agency Name: _____	
Client Name: _____ First Last		Client Zip Code: _____	Client County: _____	Date of Contact: ____/____/____ Month Day Year	
Representative Name (if applicable): _____ First Last		Beneficiary Phone Number: (____) ____ - ____		First vs. Continuing Contact: <input type="checkbox"/> First Contact for Issue <input type="checkbox"/> Continuing Contacts for Issue	
How Did Client Learn About SHICK: (Check only one) <input type="checkbox"/> Previous Contact <input type="checkbox"/> CMS/Medicare <input type="checkbox"/> Presentations <input type="checkbox"/> Mailings <input type="checkbox"/> Another Agency <input type="checkbox"/> Friend or Relative <input type="checkbox"/> Media <input type="checkbox"/> State Website <input type="checkbox"/> Other	Method of Contact: <input type="checkbox"/> Phone Call <input type="checkbox"/> Face to Face at Counseling Location or Event Site <input type="checkbox"/> Face to Face at Client's Home/Facility <input type="checkbox"/> E-Mail <input type="checkbox"/> Postal Mail or Fax Client Primary Language Other Than English <input type="checkbox"/> Primary Language Other Than English <input type="checkbox"/> English is Client's Primary Language	Client Age Group: <input type="checkbox"/> 64 or Younger <input type="checkbox"/> 65 – 74 <input type="checkbox"/> 75 – 84 <input type="checkbox"/> 85 or Older Client Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Client Race-Ethnicity: <input type="checkbox"/> Hispanic, Latino, or Spanish Origin <input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Some Other Race-Ethnicity		
Client Monthly Income: <input type="checkbox"/> Below 150% FPL <input type="checkbox"/> At or Above 150% FPL		Client Assets: <input type="checkbox"/> Below LIS Asset Limits <input type="checkbox"/> Above LIS Asset Limits		Receiving or Applying for: Social Security Disability or Medicare Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

» » » CHECK ALL TOPICS IN THE SHADED AREA BELOW THAT APPLY TO THIS COUNSELING SESSION « « «

PRESCRIPTION DRUG ASSISTANCE Medicare Prescription Drug Coverage (Part D): <input type="checkbox"/> Eligibility/Screening <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Plans Comparison <input type="checkbox"/> Plan Enrollment/Disenrollment <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Appeals/Grievances <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Marketing/Sales Complaints or Issues <input type="checkbox"/> Quality of Care <input type="checkbox"/> Plan Non-Renewal Part D Low Income Subsidy (LIS/Extra Help): <input type="checkbox"/> Eligibility/Screening <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Application Assistance <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Appeals/Grievances Other Prescription Assistance: <input type="checkbox"/> Union/Employer Plan <input type="checkbox"/> Military Drug Benefits <input type="checkbox"/> Manufacturer Programs <input type="checkbox"/> State Pharmaceutical Assistance Programs <input type="checkbox"/> Other (Specify) _____	Medicare Advantage (HMO, POS, PPO, PFFS, SNP, MSA, Cost): <input type="checkbox"/> Eligibility/Screening <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Plans Comparison <input type="checkbox"/> Plan Enrollment/Disenrollment <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Appeals/Grievances <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Marketing/Sales Complaints or Issues <input type="checkbox"/> Quality of Care <input type="checkbox"/> Plan Non-Renewal Medicare Supplement/Select: <input type="checkbox"/> Eligibility/Screening <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Plans Comparison <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Appeals/Grievances <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Marketing/Sales Complaints or Issues <input type="checkbox"/> Quality of Care <input type="checkbox"/> Plan Non-Renewal Status: <input type="checkbox"/> General Information and Referral <input type="checkbox"/> Detailed Assistance – In Progress <input type="checkbox"/> Detailed Assistance – Completed <input type="checkbox"/> Problem Solving/Resolution–In Progress <input type="checkbox"/> Problem Solving/Resolution–Completed	Medicaid: <input type="checkbox"/> Medicare Savings Program (MSP) Screening (QMB/SLMB/QI) <input type="checkbox"/> MSP Application Assistance <input type="checkbox"/> Medicaid (SSI, Nursing Home, MEPS, Elderly Waiver) Screening <input type="checkbox"/> Medicaid Applications Assistance <input type="checkbox"/> Medicaid/QMB Claims <input type="checkbox"/> Fraud and Abuse Other: <input type="checkbox"/> Long Term Care (LTC) Insurance <input type="checkbox"/> LTC Partnership <input type="checkbox"/> LTC Other <input type="checkbox"/> Military Health Benefits <input type="checkbox"/> Employer/Federal Employee Health Benefits <input type="checkbox"/> COBRA <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> Other (Specify) _____ MIPPA MIPPA Client (Circle One) 1 2 3 1-LIS Application 2-MSP Application 3-LIS and MSP Applications
MEDICARE (Parts A & B): <input type="checkbox"/> Eligibility <input type="checkbox"/> Benefit Explanation <input type="checkbox"/> Claims/Billing <input type="checkbox"/> Appeals/Grievances <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Quality of Care	Estimated Cost Savings: \$ _____ Total Time Spent on This Contact Date: _____ Hours _____ Minutes	